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Health Care Coverage

Understanding Your Health Insurance Options

Published by the Office of Washington State Insurance Commissioner Mike Kreidler

Dear Health Care Consumer:

In the past few years, the face of health care in Washington State (and across the country) has changed dramatically. Many of these changes directly affect your rights and options as a consumer of health insurance/coverage products, and in some cases may affect your access to coverage as well as care.

To help you keep up with the constant changes in the individual health insurance market, understand your rights and options, and obtain health care coverage that meets your needs, my staff has prepared this consumer guide. It will help you understand:

- what kind of health plan may be best for you and your circumstances;
- how different types of health care plans work, and;
- how to obtain quality care and fair treatment from your health care providers.

I cannot emphasize enough how important it is for consumers to have adequate health insurance. Uninsured people may avoid getting treated for medical conditions that may escalate into major health and financial problems.

If you have insurance questions or concerns, call our Consumer Hot Line at **1-800-562-6900.** Our Consumer Advocacy staff includes experts in all lines of insurance (auto, homeowner, life, disability and health) and provides free assistance and education to consumers. Consumer Advocacy also has the authority to investigate formal complaints against insurers and enforce insurance law on behalf of consumers.

For additional help with health insurance issues, Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of my office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. To be referred locally for assistance, call **1-800-397-4422.**

Please let me know how else we can help.

Sincerely,

Mike Kreidler
Washington State Insurance Commissioner

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Section 1

Defining Your Needs and Eligibility

Health care coverage is always evolving, and health insurance and health care access issues are increasingly complex in today's market. You must be sure that the health care system you choose meets your needs.

Different kinds of health coverage plans are available based on your current needs, personal circumstances and financial resources. This section is organized around discovering what kind of policy or plan you may need, are eligible for, and can afford.

Consumers who might need to turn to the individual market to purchase health care coverage include those who do not have insurance through their own employment or that of a spouse or parent. While a large percentage of people do have their primary health coverage through an employer, there is an increasing population of individuals who do not have access to employment-related benefits.

What if your employer's health plan does not meet your needs? Perhaps the plan doesn't cover your spouse or dependents, is too expensive, or you haven't worked long enough in the company to qualify. Or you may have to wait for an "open-enrollment" period (usually the same month each year). In those cases, you may want to look into buying your own individual policy.

Real-life situations in which entering the individual market for health care coverage may be necessary:

- You lost your job due to a layoff.
- You decided to stay home with your children, and are not returning to work at the end of maternity leave.
- You just moved to Washington from another state and need insurance.
- You will no longer be covered under your parents' policy.

Check with your plan administrator to find out if you have benefits or coverages mentioned in this guide. Several types of health insurance plans, to include self funded and union trusts, are exempt from state regulation under federal law.

- The rates for family health insurance where you work are too high for all of you to be covered. If you continue on your policy, you need coverage for your spouse and/or children.
- Your kids need insurance to play sports at school.
- You are self-employed and don't have health insurance.
- You work one or more part-time jobs, and none offer benefits.

Employment-related coverage

If you are working now or recently left work, you might qualify to purchase the following types of coverage:

• Group plans

If either you or your spouse are working, you may be able to obtain health benefits through the employer. Unlike those enrolling in an individual plan, if you are enrolling in a group plan you do not have to take the health screen as explained on page 9. Group plans cannot reject you based on health status. For more information, check with the plan's administrator.

• Self-employed

If you are self-employed or a sole proprietor, you may be eligible for a small group plan. Single-proprietor businesses or self-employed people qualify as "groups of one." Washington state law allows single-owner businesses to buy in the group market, even though the only people covered under the plan will be the business owner and his or her dependents.

To be eligible for small group rates, you must:

- **derive at least 75%** of your income from your business, and;
- **have filed the IRS Form 1040, or** Schedule C or F, during the preceding year.

If you meet these requirements, you cannot be turned down by a health carrier for small group coverage. Some carriers have not been eager to market these plans, but state law requires they be available. Consumers who encounter resistance may contact the OIC for advice or assistance at 1-800-562-6900.

• Professional organizations and association plans

Another kind of group plan is sometimes offered through professional organizations, such as local boards of Realty, or the Chamber of Commerce in a community. These health plans are often accessible to people in a particular industry, profession or professional group.

Additionally, you may be eligible for health insurance through a religious, fraternal, or business association. **Some of these health plans are either not regulated by the OIC or are regulated differently than traditional health plans.** Therefore, your rights and legal protections may be limited.

Association plans may not be major medical coverage. Although there may be similarities to group plans, it is important for shoppers to fully understand the exact benefits they are purchasing, so they are not surprised by limited coverage later on. In some cases, it may be advisable to purchase riders to the basic coverage to make sure you have a complete package of benefits. It is also very important to get this information in writing.

While association plans are offered statewide and sometimes at very competitive rates, it is common to hear of subscribers who did not fully understand the benefits they purchased and are disappointed to learn that an illness or treatment falls outside the terms of coverage.

For more information on these options, please visit the OIC web page at **www.insurance.wa.gov** or call the Consumer Hot Line at **1-800-562-6900**, or SHIBA HelpLine at **1-800-397-4422**.

If you are leaving your job, divorcing an employed person, or otherwise being separated from an employment-related plan, you should ask the employer if you are eligible for COBRA benefits. COBRA enrollees can continue benefits at their own cost for up to 18 months. Spouses and dependents can continue benefits 18-36 months, depending on their circumstances.

• COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed in 1986. It provides for availability of health benefits to employees who are terminated or lose medical coverage because their hours are reduced. Group health plans provided by companies with 20 or more employees are subject to COBRA.

If an employee, spouse, or dependent was covered by the group health plan on the day before a qualifying event (see below), then the employee, spouse, or dependent may be eligible to buy continued coverage under the group plan for 18-36 months (18 months for the employee, 36 months for the dependent in the event of the death of or divorce from the covered employee).

The federal Centers for Medicare and Medicaid Services (CMS), which administers the Medicare progam, also publishes helpful guides, such as *Guide to Health Insurance for People with Medicare; Medicare & You; Your Medicare Benefits; Medicare and Other Health Benefits,* and others. Visit them on the web at **www.medicare.gov** or call **1-800-MEDICARE.**

A qualifying event for an employee is reduction in hours or losing a job for reasons other than "gross misconduct."

A qualifying event for a spouse or dependent includes reduction in hours or termination of the covered employee (as described above), plus:

Divorce or legal separation from the covered employee;
Death of the covered employee, or;
Entitlement to Medicare by the covered employee.

Beneficiaries must pay for COBRA coverage themselves. They may be charged up to 102 percent of the total cost of the group plan, which includes the portion usually paid by the employer.

In June 1998, the U.S. Supreme court ruled that COBRA coverage may not be denied when other group health coverage is present on or before the COBRA election day. An individual who already has other coverage (including Medicare) on or before the date he or she becomes eligible for COBRA may continue that coverage along with COBRA coverage.

But if an individual qualifies for Medicare ***after*** qualifying for COBRA coverage, the employer may (is allowed to) terminate the COBRA coverage. Not all plans terminate COBRA coverage immediately upon Medicare eligibility, so check with the plan administrator.

Warning: If you are enrolled in Medicare Part A (hospital coverage) and you elect COBRA but fail to enroll in Medicare Part B (medical coverage), you may be subject to penalties and to a delay in coverage under Part B when your COBRA expires. This delay in coverage could leave you without medical insurance for up to 16 months, depending on the date your COBRA expires.

Depending on circumstances, dependents may be able to continue COBRA coverage even if the primary employee (ex-employee) becomes Medicare-eligible.

Continuation Coverage is a limited form of COBRA for consumers leaving small employers with 20 or fewer employees.

For more information on COBRA, call the Department of Labor (DOL) Pension and Welfare Benefits Administration at 1-800-998-7542 or check with your employer's Human Resource office.

Coverage for Individuals and Families

If you are not working now or did not recently leave work, and are not eligible for Medicare, there are several kinds of insurance programs available:

- Individual and family plans from commercial health plans
- Individual and family plans sponsored by government agencies

Commercial health plans

Currently, there are two general types of health insurance policies being sold in Washington state.

1. **Managed care plans**, often known as Health Maintenance Organizations (HMOs).
2. **Fee-for-service or indemnity plans**, also known as "major medical" plans.

Each type of policy has its pros and cons. Here is how they work:

• Managed care

Most health insurance sold in Washington state today operates under the principle of managed care. Managed care is a philosophy of providing health care at the most efficient level. Typically, managed care systems restrict their subscribers to a specified network of providers, and require subscribers to deal with a "gatekeeper" who tries to make sure that patients do not receive inappropriate health services or undergo procedures unnecessarily.

Managed care plans require consumers to obtain their health care from a large organization or network of professionals. You visit a physician you have chosen from among the managed care plan's network of providers.

Managed care systems may differ greatly from one another. Some allow more freedom than others when selecting a personal physician or other specialist. They also may use different systems of "co-payment," a small, upfront charge the consumer pays during an office visit. Depending on your personal circumstances, these differences may be important to you. Ask about the features of any plan before you enroll and be sure you understand how they work.

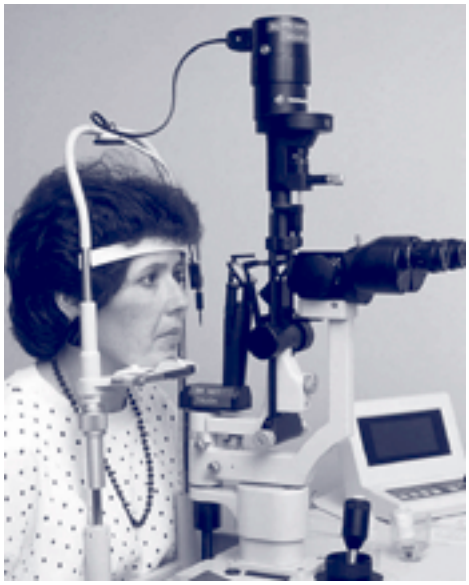
Remember: You can quickly locate help by calling our toll-free Consumer Hot Line at **1-800-562-6900.**

A managed care premium often covers educational / wellness programs and some preventive exams and routine services, along with diagnostic services and treatment. Your fixed monthly premium (if any) pre-pays as much care as is medically necessary.

With managed care, out-of-pocket expenses come in the form of plan-specified co-payments that some plans assess for some services. These often range from $5 to $20 per visit. For services not approved / covered by the plan, you pay the full amount. The plan usually coordinates bills and payments.

The following are types of managed care organizations.

- **Health Maintenance Organization (HMO).** An HMO provides health services through a network of doctors, hospitals, laboratories, etc. The health care providers may either be HMO employees or have some other contract arrangement with the HMO. Typically, HMO plans pay providers a monthly fixed amount regardless of the amount of services performed. When you enroll in an HMO, you choose one of the doctors as your primary care provider (PCP) to manage your health care. Whenever you need health care, you first consult your PCP; he or she then may refer you to an HMO-approved specialist.



- **Health Care Service Contractor (HCSC).** Like HMOs, Health Care Service Contractors offer their services through networks of health care providers who agree by contract to work for the carrier. HCSCs are organized under a different section of Washington's insurance code, so they follow a different set of regulations and requirements. However, there is usually little difference apparent to the consumer. Consumers choosing between HMOs and HCSCs should review specific individual benefits, such as travel care or reimbursement levels.

• Fee-for-service/indemnity

Fee-for-service plans allow consumers to act independently in choosing health care professionals and hospitals.

The "fee-for-service" system is a pay-per-visit arrangement. You see any licensed provider you choose when you need a treatment, service or exam. You are billed each time you receive care. Depending on the service, and your insurance coverage, your policy will cover part of the bill or none. Doctors and other providers in individual or group practice are paid by the insurance company for each service (e.g., office visit, tests).

Usually there is a deductible (amount you pay out of your own pocket before your coverage "kicks in"). You are also responsible for coinsurance (a percentage of each expense that you must pay each time a service or treatment is rendered) and any out-of-pocket expenses (the full fees for services not covered by your insurance). How much of these expenses you pay out of pocket depends on the extent of your insurance coverage.

Every carrier must provide a brochure that compares the benefits of different plans, whether comprehensive or catastrophic coverage for small group plans.

- **A comprehensive plan** covers most services, often after you pay a deductible. It is more costly than a catastrophic plan (see below).
- **A catastrophic plan** has higher deductibles and pays a lower percentage of medical expenses than a comprehensive plan. This allows for a cheaper premium. You pay more out of pocket up front when you receive care, but once the deductible is met, the plan will pay (at the plan's designated percentage) for any covered medical costs.

• Preferred provider organizations (PPO)

PPOs are not insurance carriers but groups of providers who sell their services by contract to carriers. PPO plans may allow subscribers to select their own providers and receive direct reimbursement of valid health-care costs. Although these plans are less common, they may be offered by either HCSCs (see page 7) or commercial carriers.

• Point-of-service plans

Point-of-service plans allow their subscribers to go to providers outside the network, but usually reimburse costs at a lower level than network providers.

To determine which type of plan may be best for you, see section 2 of this guide, which discusses how to evaluate health coverage choices and how to use your health coverage effectively.

Health Screening and the Individual Market

Under a law passed by the 2000 session of the Legislature, insurers may now impose a nine-month pre-existing condition waiting period before your policy covers any health condition for which you were treated during the past six months. However, the new carrier must give you credit against the waiting period, equivalent to the number of months of continuous coverage you had previously. For example, if you had nine months of coverage under your immediately preceding plan, your waiting period will be waived. However, if you were on your former plan for only four months, you will still have to wait five months for the new insurance to cover a pre-existing condition. This continuous coverage needs to have been under an employer-sponsored group health insurance, or comparable coverage on an individual health plan immediately preceding your new one. In either case, you must apply for new insurance within 63 days after losing your old coverage. Catastrophic coverage is not deemed comparable.

Also due to this legislation, most health insurance applicants in the individual market will be required to undergo a health screening questionnaire to qualify for individual coverage. The screen is a questionnaire designed by the Washington State Health Insurance Pool (WSHIP) to identify the eight percent "sickest" (i.e., most costly) applicants for health insurance, based on health history. If an applicant is identified as too sick for normal individual coverage, those applicants may be turned down by carriers.

When you contact a health plan, they will send you an application packet that includes the health screening questionnaire. If you don't pass the screen and are turned down for individual coverage, you will automatically become eligible for health insurance through WSHIP.

WSHIP members can select between network and fee-for-service plans, as well as different deductible amounts, both potential ways of lowering the cost for health coverage. Some discounts are also available for WSHIP members.

For questions about the health screen questionnaire, its scoring, and WSHIP coverage and rates, call WSHIP at 1-800-877-5187, or visit the WSHIP web site at http://www.onlinehealthplan.com/oasys/wship/

For more on WSHIP, see page 14 of this guide.

Individuals Not Required To Take the Health Screen

The new law generally applies to anyone buying new coverage without previous coverage. However, certain consumers will not be required to undergo health screening. They include:

- **People who have exhausted COBRA coverage.** (This does not mean people have to wait for their COBRA coverage to expire before applying to a new plan. In fact, consumers should apply in advance, because new coverage typically will not begin for 30 days.)
- **Medicare beneficiaries.**
- **People seeking a different product** because they are relocating from one area to another within Washington state.
- **People who are applying for new coverage** in order to stay with the family doctor.

Plans Sponsored by State and Federal Agencies

In general, these plans are meant to help people who cannot afford insurance in the individual market or have very expensive health care needs. Some programs are specifically meant for people who are disabled or who have limited incomes and resources. Often, people are not aware of their eligibility for these programs.

Basic Health

The state of Washington subsidizes a public health program called Basic Health (BH) for Washington state residents whose income is too high to qualify for public assistance (Medicaid), but too low to afford individual coverage. Developed by the Washington State Legislature, the plan has changed over the years, but the current system generally provides coverage based on the family's income level.

BH is a managed care plan sponsored by the state and administered through private insurance carriers. It is a comprehensive health plan covering prescription drugs, maternity, and major medical costs. However, it does not cover registered physical therapy, eye and hearing exams, artificial limbs, or medical equipment such as wheelchairs or back braces.

As is typical of managed care, you must use the services within a network of providers in your area. Besides paying a monthly premium, you will have to make a small co-payment each time you visit your health care provider.

A limited number of slots are set aside for people who will pay on a sliding scale, with premiums based on income, age, family size, location and choice of carrier. If all slots are full, BH operates under a "managed enrollment," staggering the effective dates of coverage for enrollees and allowing more to enroll when some enrollees leave the plan.

Local health carriers offer BH, under the authority/jurisdiction of the Washington State Health Care Authority.

If you meet the income qualifications, you may be eligible for the Basic Health reduced premium program. Benefits, rates, and other details are available by calling 1-800-826-2444 or visiting the BH website at www.wa.gov/hca/basichealth.htm

Medicaid

Medicaid is a publicly-funded program that provides health insurance to specific categories of people who meet financial eligibility requirements. Medicaid was created by the federal government and is usually administered by state governments. The federal government (the Centers for Medicare and Medicaid Services [CMS], formerly the Health Care Financing Administration [HCFA]) provides oversight and some funding to Medicaid programs.

In Washington state, Medicaid programs are administered by the Medical Assistance Administration (MAA) of the Department of Social and Health Services (DSHS). These programs are offered through a number of local Community Services Offices.

Medicaid is actually a complex system of programs, requirements and benefits. There are many different Medicaid programs, for specific eligibility groups. In Washington, those groups are pregnant women, children, disabled individuals, persons over the age of 65 ("the aged") and refugees/aliens. In some limited instances, certain people who do not fall into these categories may be eligible for limited emergency coverage (if they have no other coverage).

Here are the main types of Medicaid programs offered to different categories of individuals. This chart is designed to provide you with a quick reference to these programs.

Medicaid Program	Eligibility
Categorically Needy Program (CN)	Aged, blind, disabled, pregnant women, children and refugees who meet income requirements.
General Assistance Programs	Some persons who are eligible for Alcoholism/Drug Treatment Services and those who are classified "unemployable" due to a physical or mental disability.
Long Term Care and Community Options Program Entry System (COPES)	Persons who are in need of (or at risk of) being institutionalized in a nursing home (must meet financial guidelines).
Medically Indigent Program	People who have an emergency condition requiring hospitalization and are not eligible for other coverage.

The Categorically Needy program is a Medicaid program for the aged, blind, disabled, pregnant women, children and refugees. Persons may be eligible for CN only, or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CN includes a full scope of coverage for pregnant women and children. This is the Medicaid program with the broadest health coverage.

The Medically Needy program (MN) is a Medicaid program for the aged, blind and disabled, pregnant women, children and refugees whose income and resources are too high to qualify for the Categorically Needy Program (see above). The Medically Needy program provides slightly less coverage than the CN program and requires greater financial participation on the part of the clients.

The Medically Indigent (MI) program provides very limited medical coverage for persons with an emergency medical condition requiring hospital services. This program is available only for persons who are not eligible for any other medical program. Income and resource limits for the MI program are the same as for MN. Clients with excess income and/or resources above MI limits must spend down the excess before they are eligible for MI.

MI clients with an emergency medical condition may receive coverage for:

- **Ambulance/emergency transportation**
- **Emergency room services**
- **Inpatient/outpatient hospital care**
- **Physician services in the hospital**

Healthy Options

Healthy Options is the name of the Medicaid managed care program. Under Healthy Options, a consumer is enrolled in a health plan and needs to have a Primary Care Provider (PCP). Consumers need referrals for specialist care.

Unless you receive SSI, Medicare, or qualify for an "exemption" from Healthy Options, Medicaid recipients must enroll if they are:

- **a parent or relative** caring for a child or children, or
- **a child under age 19,** not in foster care, or
- **pregnant.**

Exemptions from Enrollment:

An exemption from Healthy Options can allow consumers to get medical care from their choice of providers who take medical coupons, without being limited to a single plan or PCP. You may qualify for an exemption if you:

- **have good reason why** care is not reasonably available under any plan. For example, the plan cannot meet a specialized health care need (and it is documented by the current provider);
- **are pregnant and already being seen** by another provider who is not in a plan;
- **are homeless;**
- **are an immigrant;**
- **have a provider who is not in a plan,** and disrupting the treatment plan might be harmful to your health;
- **have a hardship getting care** from a plan because of distance or travel time;
- **already have a provider who speaks** your first language and cannot find a provider in the plan who does;
- **are a Native American or Alaska Native,** in which case you are automatically exempt and are only enrolled in Healthy Options if requested;
- **have managed care coverage** through medical insurance other than Medicaid.

You may request an exemption by calling 1-800-794-4360, or by contacting your DSHS caseworker. It is best to submit a written request with supporting medical or other evidence.
If DSHS denies the exemption, they must send you a notice explaining the reasons and your right to a fair hearing.

For more information on Medicaid and Healthy Options, you can go to http://hcfa.hhs.gov/medicaid/mcaicnsm.htm or wws2.wa.gov/dshs/maa/index.html

Washington State Health Insurance Pool (WSHIP)

As stated earlier in the discussion of health screening in the individual market (page 9), the Washington State Health Insurance Pool (WSHIP) provides health insurance for people who are unable to obtain coverage in the private marketplace. This plan provides comprehensive coverage, including a prescription drug benefit. Premiums are based on age and geographic location.

You are only eligible for this plan if you have failed the health screen for individual coverage (see page 9). If you do fail the health screen, the carrier you applied to will automatically send you an application for WSHIP.

There are two WSHIP options available for people who are ***not*** on Medicare:

- The Standard Plan (Plan 1), which is fee-for-service, allows you to go to the doctor of your choice;
- The Network Plan (Plan 3), which is a managed care plan, uses providers from the First Choice network.

WSHIP also has a separate plan that is only available for people on Medicare (Plan 2.) This plan has different eligibility criteria.

In the fee-for-service plan, rates are set at 150% of the average market rate for comparable commercial coverage. Rates for the network plan (managed care) are 125% of the average market rate. Some discount rates will be given to people over 50 with low income and people who have been in WSHIP for more than three years. For further information about WSHIP, contact the administrator, OASYS: **1-800-877-5187** or **www.onlinehealthplan.com/oasys/wship/**

Coverage for Kids

More than 100,000 children and teenagers in Washington state are without health insurance. However, there are several insurance programs available especially for children.

Basic Health Plus

Basic Health Plus is a Medicaid program for children in low-income households. There are no copayments for services and no monthly premium; DSHS pays the entire cost of coverage. It offers added benefits and services for children, including vision and dental benefits, and transportation to medical services.

If you are on Basic Health, your children may be eligible for Basic Health Plus. They must be under age 19 and U.S. citizens, or legal residents who arrived in the U.S. before Aug. 22, 1996.

Children not living in your household may be enrolled in Basic Health (see page 10) but not Basic Health Plus.

For more information call **1-800-826-2444** or visit the Basic Health website at **www.wa.gov/hca/basichealth.htm**

Medicaid: Children's Medical

The Children's Health Program is the program for children under age 18 who are not eligible for Medicaid because they are non-citizens, including visitors or students from another country and undocumented children. This program has no resource limit and its income limit is based on 100% of the Federal Poverty Level (FPL). Medical coverage is the same as for CN (Categorically Needy). Living with a relative and citizenship are not eligibility requirements for the Children's Health Program. For more information on this program, go to **www-app2.wa.gov/dshs/eazmanual/Sections/PS_MedProgs.htm** or call **1-800-562-3022.**

Office of the Insurance Commissioner
P.O. Box 40255
Olympia, Washington 98504-0255

Need help with an insurance problem or question? The Insurance Commissioner's Consumer Advocacy division has experts in all lines of insurance (auto, homeowner, life, disability and health) who can assist you. Call our toll-free hot line at

1-800-562-6900

In addition, if you need help with health coverage issues, Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of the Insurance Commissioner's Office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. To be referred locally for assistance, call

1-800-397-4422

Also see these other publications by the Office of the Insurance Commissioner

- Cutting Prescription Drug Costs
- Retirement and Your Health Insurance
- Medicare, Medigap and You
- Consumer's Guide to Financing
- Long-Term Care Insurance
- Medicare Choices
- It's Your Choice - Consumer Guide to Complementary and Alternative Health Care
- Women's Direct Access to Health Care Providers
- From the Ground Up - Consumer Guide to Homeowner Insurance
- In the Driver's Seat - Consumer Guide to Auto Insurance
- The Facts of Life - Consumer Guide to Life Insurance
- Homeowner Complaint Report
- Automobile Complaint Report
- Insurance Decoded - Consumer Guide to Insurance Terms

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